Division of Developmental Disabilities
Department of Behavior Health Developmental Disabilities
DISCHARGE CHECKLIST FOR TRANSITION T**O COMMUNITY PLACEMENT**

For Individual: _____ SS#: _____

Discharge From: _____ DOB: _____

Step	Responsible Person	Action Step	Results
1. Complete and submit to appropriate region a Medicaid waiver application, and all supporting required documentation for individuals on transition including verification of legal guardianship if applicable.	DD Chief		
2. Review Medicaid application and determine waiver eligibility. Send out waiver award letter and another letter with information on support coordination. (The choice of Support Coordination Agency will be made at the Transition meeting.)	Regional I&E Manager		
3. Confirm current Medicaid code, waiver eligibility and MFP eligibility as well as documentation of individual financial resources (1 month in ICF/MR, SNF or private nursing home, Medicaid eligible).	DD Chief/ Hospital Patient Accounts		
4. Ensure that each individual on Transition list has a Hospital Planning List Administrator.	Hospital Case Expediter		
5. Convene the support team and identified current stakeholders with the individual/family to review and update person-centered plans to determine individualized support needs including living arrangements, staffing needs, medical supports, employment opportunities, and educational arrangements if applicable (***Person-Centered Descriptions***).	Hospital Planning List Administrator		

6. Within 30 days of PCD meeting, disseminate updated person centered description information to division (for uploading on K Drive) individual's family and to potential providers for review.	Hospital Planning List Administrator/ DD State Case Expediter		
7. With the assistance of the support network the individual/family chooses the service provider(s) and informs the Region. (This includes scheduling visits to potential homes.)	Hospital Planning List Administrator		
8. As soon as a provider has been selected, schedule and conduct **transition meeting** utilizing the Guidelines for Transitional Planning and the Person Centered Description. During this meeting w/provider, a **reasonable discharge date** must be set & documented with assignments and dates of needed tasks to meet the d/c date. Review financial records, burial information and other Medicare Part A, B, or D information for eligibility. **Review all medications, ensure that meds are on community formulary, and appropriate informed consent for psychotropic medication is completed.** Ensure hospital staff has completed SIS (SIS must be current within 120 days of beginning of service). Review need for ERR and provider begins development of ERR. Required documentation to Division for community allocation. Review need for start-up and begin development of start-up request.	Hospital Planning List Administrator		
9. Develop any MFP demonstration and transition services (for MFP eligible participants) and/or start-up requests and submit to Transition Coordinators (Sally Carter, Bobbie Davidson, & Jenny Weismann). The completed **Transition Agreement form** and **Transition Fund Request Forms** are due to the	HPLA/Provider		

applicable Regional Office within 10 business days from the date of the Transition Meeting.			
10. As soon as meeting transition meeting is completed the information and date is entered into the CIS. The Transition Planning Guideline document must be uploaded into CIS within 10 business days from the transition meeting date.	Hospital Case Expediter		
11. Request completion of Regional pre-placement site approval.	Hospital Planning List Administrator		
12. When home is selected, verify status of provider number and/or HFR status for site as indicated. Request expedited process if necessary.	Hospital Case Expediter		
13. Request approval for out of Region placement (if applicable).	Regional Service Administrator-DD (HPLA, HCE)		
14. Schedule and conduct the ***ISP*** meeting. Provider completes ERR and submits request, if needed with ISP. If ERR is needed for behavioral issues, a temporary BSP must be submitted with package.	Hospital Planning List Administrator/ Provider		
15. At the ***ISP*** meeting (**usually held 30 days prior to discharge) c**omplete and/or update all required assessments including ***HRST,*** nursing, social work, and psychological and submit to I&E LOC Nurse. In addition, 30 days prior to discharge complete and submit DMA-6 and the top section of the MAO to I&E LOC Nurse. If the discharge does not occur, the ***ISP*** and assessments will need to be amended.	DD Chief		
16. When Hospital Planning List Administrator (PLA) notifies the I & E office that the ***ISP*** and assessments are complete, the Intake & Evaluation (I&E) office will acknowledge receipt of Individual Service Plan (ISP) and notify the PLA of approval	I & E Manager		

within 2 weeks; approves the ***DMA6***, ***MAO***, and forward the approval to PLA and Provider. (An Exceptional Rate Request and/or Waiver of Standards Request (if applicable) are sent to the Division of DD for approval).			
17. Ensure that the individual has an appointment with the primary care physician within one month after discharge. In addition, the name, address and phone number of the dentist and other required medical specialists should be identified and entered in CIS.	Hospital Case Expediter/ PLA		
18. A. On the day of discharge if MFP Eligibility Criteria has been determined, the following information must be submitted to: Tiffany Butler, Sally Carter, Bobbie Davidson: 1) Physical address for the residence the person is moving, 2) DMA 6, 3) DMA 59, & 4) MAO Communicator B. **If ineligible for MFP, the hospital should provide the agency provider the relevant documents listed above for follow-up with DFCS office for the Medicaid category changes**.	Hospital Contact Individual		
19. Provide the following to the community provider on day of discharge: individualized information from hospital record, **current Medicaid card**/**Medicare Card/Plan**, **5 day supply** of medications, prescription(s) for an additional 30 days, a copy of the informed consent for psychotropic medication, adaptive equipment in good repair, clothes packed in a suitcase with inventory, personal belongings packed with inventory, Spending money (if available) and **current financial statement**, contact information for friends from the hospital and decision tree of	DD Chief/Hospital Contact Individual		

names and numbers of hospital staff to contact in case of questions.			

20. Submit the ***Day of Discharge Checklist*** within 3 days of discharge to Tiffany Butler, Division of DD			
21. After approval of all necessary documentation the Regional Office staff (OA) creates and enters the ***Prior Authorization(s)*** with a copy to provider.	I&E Manager/OA		
22. After Discharge: If medical and/or behavioral issues are present, the Hospital PLA and appropriate I & E staff, make joint visits until a PA is created, the individual is admitted into a Support Coordination Service, and a Support Coordinator is identified. The PLA completes a monitoring report. The Hospital PLA and the assigned Support Coordinator will make at least one joint visit to the home and ensure continuity of care. PLA will ensure that SC has copy of PCD/ISP.	Support Coordination Agency, Hospital PLA, and I & E staff		
23. Upload completed Discharge Checklist into CIS	Hospital CE		